

Welcome to SILVA CHIROPRACTIC

Thank you for choosing our office for chiropractic care. We would like to take a brief moment to welcome you into our office as the newest member of our growing family of patients. Moreover, we wish to thank you for the vote of confidence you have shown by selecting our office for your healthcare needs.

Our goal is to optimize your Neuro-musculoskeletal function through gentle spinal adjustments, adjunctive therapies and lifestyle changes. We strongly advocate a team health care concept and will make appropriate referrals to medical doctors and other health care specialists to best serve your needs. Our mission is to treat you ethically and respectfully while improving your health and well being.

In addition to your in-office treatments, you may be given specific recommendations for you to incorporate into your daily routine. The purpose of any lifestyle recommendations you may be given is to enhance your body's ability to heal itself. Some examples may include: posture awareness, proper lifting techniques, exercise, nutritional supplements and dietary changes. Your active participation in your health care program is imperative. The state of your health is very much our concern and we hope that you will allow us to help you.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members.

Finally, if you know of any friends or family members that you feel may benefit from our type of health care services, please let them know about us. Helping others is what our practice is all about.

At Silva Chiropractic, our goal is to help you

and your family live your life without limits!

SILVA CHIROPRACTIC



Confidential Patient Health Information

Personal Information:

Name: _____
First Middle Last Sex M F

E-mail address: _____

Address: _____ City/ST _____ ZIP: _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____ X _____ Cell Phone () _____ - _____

SS#: _____ / _____ / _____ Birthdate: ____ / ____ / ____ Marital Status: ____ (Married, Single, Other)

Employer: _____ Occupation: _____

Nearest Relative: _____ Relationship: _____ Phone: () _____ - _____

Primary Doctor: _____ Location: _____ Phone: () _____ - _____

Whom can we thank for referring you? _____

Would you like to receive appointment reminders? Text my cell(initial) _____ Email me(initial) _____

Insurance Information:

- I have no insurance, I will be paying out of pocket
- I have an HMO Insurance Plan
- I have a PPO Insurance Plan
- I have Medicare Insurance
- I was in an auto accident and I have Med Pay
- I was in an auto accident and I don't have Med Pay
- I have a work related injury and I expect my employer to pay

Please provide us with your insurance card so that we can make a copy.

Reason for your Visit:

Have you been to this clinic before? Yes No

Purpose of this appointment _____

Reason for your visit is a result of (please circle): Acute Injury, Chronic Problem, Auto Accident, Wellness, Work Injury, Other

Date of accident/injury, or when condition began: _____ / _____ / _____

Please describe the pain and its location: _____

Pains are: Sharp Dull Constant Intermittent

Is condition getting... Better Worse Staying the Same Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other

Have you been treated by another doctor for this condition? Yes No

If yes, please name doctor/health care facility: _____

Other Symptoms:

Past / Present

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Arm Pain
- Wrist Pain
- Hand Pain
- Upper Leg Pain
- Hip Pain
- Knee Pain
- Ankle/Foot Pain
- Pins & Needles in Arms
- Pins & Needles in Legs
- Numbness in Fingers
- Numbness in Toes
- Shortness of Breath
- Loss of Memory
- Loss of Smell
- Loss of Taste
- Loss of Hearing

Past / Present

- Jaw Pain
- Joint Swelling
- Arthritis
- Rheumatoid Arthritis
- General Fatigue
- Visual Disturbances
- Dizziness
- Loss of Balance
- High Blood Pressure
- Heart Attack
- Chest Pains
- Angina
- Stroke
- Diabetes
- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Abnormal Weight Gain/Loss
- Loss of Appetite

Past / Present

- Abdominal Pain
- Diarrhea
- Constipation
- Ulcer
- Hepatitis
- Gall Bladder Problems
- Cancer
- A Tumor
- Asthma
- Chronic Sinusitis
- Frequent Urination
- Drug/Alcohol Dependency
- Allergies
- Depression
- Epilepsy
- Birth Control Pills
- Pregnancy
- Occupational stress
- Mental stress
- Physical stress
- Other _____

Past History:

Birth Trauma? _____

Childhood accidents? _____

Broken bones? _____

Auto Accidents? _____

Sports Injuries? _____

Other Accidents? _____

Surgery? _____

Sleeping posture: Side Stomach Back

Do have any conditions that you are under drug or medical care for? _____

What medications are you taking? _____

How Long? _____

What side effects have you experienced from the drugs and surgery? _____

Family History:

Is there a family history of: (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis _____ Cancer _____ Mental Illness _____ Diabetes _____ Asthma _____

Heart Disease _____ Stroke _____ Kidney Disease _____ Lung Disease _____ Arthritis _____

Liver Disease _____ Other _____

Office Fee Schedule and Financial Policy

<u>Service</u>	<u>Insurance Patient</u>	<u>Cash Patient</u>	<u>Medicare</u>
Consultation:	N/C	N/C	N/C
New Patient Visit:	\$120	\$108	\$109.31
New Patient Visit w/X-rays:	\$180	\$162	\$158.81
Re-Exam:	\$60	\$54	\$54
X-Rays:	\$65	\$58	\$58
Adjustment:	\$45	\$40	\$37.31
Adjustment w/Therapy:	\$65	\$58	\$55.31
Therapy a la carte:	\$20	\$18	\$18

Financial Policy

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. **You will be expected to pay for your chiropractic care at the time the service is rendered unless a previous arrangement has been made.**

- Health Insurance:** At Silva Chiropractic, we base our care on what is best for you and your family. Therefore, we have chosen not to contract with most insurance companies because it would prevent us from offering the best care possible. At this time we are In-Network with Blue Shield PPO and Blue Cross Blue Shield PPO. If you have one of these plans, you may have a deductible to pay before your co-pay will kick in. Therefore, you will be responsible for the full balance until we can verify your benefits. If you have other health insurance that has “Out of Network Benefits” that covers chiropractic care, we will bill them for you and you will receive the reimbursement.
- Cash Patient (Self pay):** You qualify as a cash patient if you either a.) have health insurance that doesn’t have “Out of Network Benefits” or b.) you don’t have health insurance. By not having to bill an insurance company, we save time and money. **We pass on the savings to you by giving you a special discount as indicated by the fee schedule above.** As a cash patient, you can pay for your care at the time of each visit, or to speed up your appointments you can prepay weekly, monthly, or yearly.
- Medicare:** We are a non-participating provider with Medicare. All that means is that you pay at the time of service and you will receive the reimbursement from Medicare. As a service to you, we will bill your services to Medicare for you. At this time Medicare only reimburses for chiropractic adjustments of the spine to correct subluxations. All exams, x-rays, and therapies are not covered by Medicare and are therefore your responsibility.

As a cash patient, you will not get receipts to submit to your insurance company. You can, however, be given a receipt for tax purposes or a medical savings account (MSA) indicating the total amount you have paid for chiropractic care during the year.

If you acquire insurance for a special situation such as an auto accident, our regular office fees will be charged to the insurance until such claim is settled.

I have read and I understand the above policies. I have initialed the one that applies to me.

Patient Signature

Date

SILVA CHIROPRACTIC - INFORMED CONSENT

I, the undersigned, have voluntarily requested that Dr. Shawn A. Silva, D.C., CKTP or Dr. Al Valenzuela, D.C. assist me in the management of my health concerns. I understand and agree to all policies and terms provided in the Office Policies and Procedures.

Chiropractic healthcare is an art and science that is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurologic evaluation and possibly x-rays) along with specialized chiropractic evaluation including observation, inspection, auscultation and palpation. The chiropractic examination focuses on structural or functional abnormalities called subluxations. Subluxations exist when one or more vertebrae in the spine or bones in the extremity are fixated sufficiently to result in damage or irritation to either nearby nerves, joints, and/or tissues, such as muscles and ligaments. The primary goal of chiropractic treatment is to remove the fixation. This is accomplished by performing a procedure unique to chiropractic called an adjustment. An adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebrae or bone. Adjustments are usually performed by hand, but may use a hand-guided instrument. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (ice, heat, muscle stimulation, ultrasound, soft tissue manipulation), nutritional recommendations and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public, as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed treatment results and common and rare side-effects/complications associated with chiropractic care.

Results from Treatment

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Possible Risks & Side Effects from Treatment

One research study indicated that within the first 2 months of care, approximately half of patients report some "reaction" to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care:

- Local Discomfort (53%)
- Headache (12%)
- Tiredness (11%)
- Radiating Discomfort (10%)

Most appeared within 4 hours of treatment and resolved within 24 hours.

Rare, yet possible side-effects / Complications:

- Rib Fracture
- Disc Herniation
- Cauda Equina Syndrome (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (1 case per 400,000 to 1 million cervical spine adjustments)

A thorough health history and physical examination will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including:

Medications: I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks that I should discuss with my medical doctor.

Rest/Exercise: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Please answer all questions below to help us determine possible risk factors:

1. Have you ever had an adverse (ie. bad) reaction to or following chiropractic care Y N
2. Have you ever been diagnosed with osteoporosis? Y N
3. Do you take corticosteroids (ie. Prednisone)? Y N
4. Have you ever been diagnosed with a compression fracture of the spine? Y N
5. Have you ever been diagnosed with cancer? Y N
6. Do you take Warfarin (coumadin), heparin or other “blood thinners”? Y N
7. Have you ever had a stroke or TIA (transient ischemic attack)? Y N
8. If you have a complaint of neck pain or headache is this unlike anything you’ve ever experienced before? Y N
9. Have you ever been diagnosed with any of the following?
 - a. Rheumatoid Arthritis Y N
 - b. Reiter’s Syndrome, Ankylosing Spondylitis, Psoriatic Arthritis Y N
 - c. Giant Cell Arteritis Y N
 - d. Ligamentous Hypermobility (Marfan’s, Ehler’s Danlos) Y N
10. Have you ever had spinal surgery? Y N
11. Have you ever been diagnosed with spinal stenosis? Y N
12. Have you ever had any of the following problems?
 - a. Sudden weakness in the arms or legs? Y N
 - b. Numbness in the genital area? Y N
 - c. Recent inability to urinate or lack of control when urinating? Y N

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent Document.

Signature of patient (or guardian) _____ Date _____

I explained the procedures, alternatives, and risks in conference with the patient.

Doctor’s Signature _____ Date _____

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for care, payment and healthcare operations. For example:

Health Care

We may use or disclose your health information to a physician or other healthcare provider providing care to you.

Payment

We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

In addition to our use of your health information for your care, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends

We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written authorization.

Required by Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we can reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practices, and our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 4/02/07. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in this Notice.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address in this Notice. If you request copies, we will charge you \$0.20 cents for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 7 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means, or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the Privacy Officer or with the Office for Civil Rights.

Privacy Officer Dr. Shawn Silva, D.C. (408) 776-8608 Fax: (408) 762-2012 Address: 18525 Sutter Blvd. Suite 170
Morgan Hill, CA 95037

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

This form does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of August 14, 2002. Subsequent law changes may require Form revision.

Patient Signature _____ Date: _____